Bereavement-related depression in the DSM-5 and ICD-11

Mario Maj

Department of Psychiatry, University of Naples SUN, Naples, Italy

The approach of the DSM-5 and ICD-11 to the issue of bereavement-related depression is going to attract a considerable attention from the mental health community and the general public. This issue, in fact, is closely linked to the more general question of what is a mental disorder, or what is the boundary between mental pathology and homeostatic reactions to major life events. It is not by chance that the DSM-IV, in its introduction (p. xxi), identifies as one of the components of the definition of mental disorder the fact that "the syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one".

Bereavement appears in the DSM-IV in the section "Other conditions that may be a focus of clinical attention", where it is stated that "as part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a major depressive episode" and that "the bereaved individual typically regards the depressed mood as 'normal'".

The DSM-IV does not totally exclude the diagnosis of major depressive episode in the presence of bereavement. It just moves the threshold upward for that diagnosis, by requiring a longer duration, a more substantial functional impairment, or the presence of specific symptoms (morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation). The aim is clearly to reduce the chance of false positives (as well as to avoid a trivialization of the concept of mental disorder).

This approach of the DSM-IV is evidence-based. First, a major depressive syndrome is indeed an "expectable response" to the death of a loved one: in the US, its prevalence among bereaved people ranges from 29 to 58% one year after the loss, and about 50% of all widows and widowers meet criteria for the syndrome at some time during the first year of bereavement (1). Second, the syndrome is indeed a "culturally sanctioned response" to the event: bereaved people and their environment accept depressive symptoms as "normal", whereas patients with primary affective disorder experience their condition as "a change", "not usual self" (2). Third, psychomotor retardation, feelings of worthlessness and suicidal ideation are less likely to be experienced by bereaved people when they have a major depressive syndrome (1).

It has been claimed that the ICD-10 is silent concerning the issue of bereavement, and that the elimination of the bereavement exclusion in the DSM-5 would contribute to the harmonization between the two systems. This is not correct. The ICD-10 Clinical Descriptions and Diagnostic Guidelines (3, p. 150) state that "normal bereavement reactions, appropriate to the culture of the individual concerned and not usually exceeding 6 months in duration" should not be coded in the chapter on mental disorders, but in chapter XXI ("Factors influencing health status and contacts with health services"). That chapter corresponds to the section where bereavement is placed in the DSM-IV. It is true that no mention of bereavement is made in the definition of depressive episode (which, as almost all ICD-10 definitions, does not contain exclusion criteria), but this mention is likely to be made in the ICD-11 (so that a change in the DSM-5 might actually create a discrepancy between the two systems).

Given this background, and considering the criteria established for DSM-5 changes (4), the removal of the bereavement exclusion from the diagnosis of major depressive episode can only be justified by a strong and unequivocal new research evidence (5). Wakefield and First's review published in this issue of the journal (6) suggests that such a solid and consistent new evidence is not available.

Bereavement-excluded major depression has been associated with a significantly lower risk of subsequent depressive episodes in two recent independent studies (7,8), which is the kind of longitudinal data previously regarded as necessary to support the current diagnostic framework (9). Furthermore, even studies usually quoted as supporting the removal of the bereavement exclusion did find that bereavement-related depression is significantly less likely than other loss-related depression to be associated with treatment seeking (10) and substantial functional impairment (11), and is marked by significantly lower levels of neuroticism and guilt (10). These are data in line with the DSM-IV approach.

Further reflection seems therefore warranted before proceeding with the deletion of the bereavement exclusion, a move that may be criticized by the mental health community as not fulfilling the criteria for DSM-5 changes ("major changes should generally require consistency of support across validators") and is likely to be perceived by the general public as a further step in psychiatry's attempt to pathologize normal human processes. A refinement of the formulation of the bereavement exclusion may, however, be needed in order to increase its predictive validity (6,12).

Acknowledgements

The author is the Chairperson of the World Health Organization Working Group on the Classification of Mood and Anxiety Disorders, reporting to the International Advisory

Group for the Revision of ICD-10 Mental and Behavioural Disorders, of which he is also a member. Unless specifically stated, this paper represents the views of the author and not the official policies and positions of the World Health Organization.

References

1. Zisook S, Paulus M, Shuchter SR et al. The many faces of depression following spousal bereavement. J Affect Disord 1997;45:85-95.
2. Clayton PJ, Herjanic M, Murphy GE et al. Mourning and depression: their similarities and differences. Can Psychiatr Assoc J 1974; 19:309-12.
3. World Health Organization. The ICD-10 classification of mental and behavioural disorders. Clinical descriptions and diagnostic guidelines. Geneva: World Health Organization, 1992.
4. Kendler KS, Kupfer D, Narrow W et al. Guidelines for making changes to DSM-5. www.dsm5.org.
5. Maj M. Depression, bereavement, and "understandable" intense sadness: should the DSM-IV approach be revised? Am J Psychiatry 2008;165:1373-5.
6. Wakefield JC, First MB. Validity of the bereavement exclusion to major depression: does the empirical evidence support the proposal to eliminate the exclusion in DSM-5? World Psychiatry 2012;11: 3-10.
7. Mojtabai R. Bereavement-related depressive episodes: characteristics, 3-year course, and implications for the DSM-5. Arch Gen Psychiatry 2011;68:920-8.
8. Wakefield JC, Schmitz MF. Recurrence of bereavement-related depression: evidence for the validity of the DSM-IV bereavement exclusion from the Epidemiologic Catchment Area Study. J Nerv Ment Dis (in press).
9. Pies RW. Depression and the pitfalls of causality: implications for DSM-V. J Affect Disord 2009;116:1-3.
10. Kendler KS, Myers J, Zisook S. Does bereavement-related major depression differ from major depression associated with other stressful life events? Am J Psychiatry 2008;165:1449-55.
11. Wakefield JC, Schmitz MF, First MB et al. Extending the bereavement exclusion for major depression to other losses. Evidence from the National Comorbidity Survey. Arch Gen Psychiatry 2007;64:433-40.
12. Wakefield JC, Schmitz MF, Baer JC. Did narrowing the major depression bereavement exclusion from DSM-III-R to DSM-IV increase validity? Evidence from the National Comorbidity Survey. J Nerv Ment Dis 2011;199:66-73.